AvMed Embrace better health® **Small Group Elite Choice S020-SG23** **Coverage for:** Individual or Individual + Family | **Plan Type:** POS

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-376-6651 or visit www.avmed.org and sign into the Member Portal. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-376-6651 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **In-Network:** $0 Individual / $0 Family<br>**PHCS Network:** $2,000 Individual / $4,000 Family<br>**Out-of-Network:** $4,000 Individual / $8,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. This plan has no In-Network deductible except for Pediatric Dental. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $60 per child for Pediatric Dental. Doesn't apply to the overall deductible. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **In-Network:** $8,000 Individual / $16,000 Family<br>**PHCS Network:** $16,000 Individual / $32,000 Family<br>**Out-of-Network:** $24,000 Individual / $48,000 Family<br>Pediatric Dental is limited to $375 per child or $750 for 2 or more children. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, prescription drug brand additional charges and manufacturer assistance, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.avmed.org or call 1-800-376-6651 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |


(DT - OMB control number: 1545-0047/Expiration DATE: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration DATE: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network (You will pay the least) | PHCS Network (outside Florida) (You will pay more) | Out-of-Network (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary Care visit to treat an injury or illness | $40 copay/ visit | $50 copay/ visit | 50% coinsurance after deductible | Additional charges may apply for non-preventive services performed in the Physician's office. |
| | Specialist visit | $80 copay/ visit | $100 copay/ visit | 50% coinsurance after deductible | Additional charges may apply for non-preventive services performed in the Physician's office. |
| | Preventive care/screening/immunization | No Charge | No Charge | 50% coinsurance after deductible | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Independent facility: $150 copay/ visit; Hospital-affiliated facility: $300 copay/ visit | Independent facility: $150 copay/ visit after deductible; Hospital-affiliated facility: $300 copay/ visit after deductible | Independent facility: 50% coinsurance after deductible; Hospital-affiliated facility: 50% coinsurance after deductible | Charges for office visits may apply if services are performed in a Physician's office. Charges for certain other labs and Specialty labs will be higher. |
| | Imaging (CT/PET scans, MRIs) | Independent facility: $750 copay/ visit; Hospital-affiliated facility: $1,500 copay/ visit | Independent facility: $750 copay/ visit after deductible; Hospital-affiliated facility: $1,500 copay/ visit after deductible | Independent facility: 50% coinsurance after deductible; Hospital-affiliated facility: 50% coinsurance after deductible | Charges for office visits or Physician/professional services may also apply depending on where services are received. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.avmed.org | Value generic drugs (Tier 1) | 30-day supply: $25 copay/ prescription; 90-day supply: $62.50 copay/ prescription | Not Covered | Not Covered | Certain limits may apply, including, for example: prior authorization, step therapy, quantity limits. |
| | Generic drugs (Tier 2) | 30-day supply: $45 copay/ prescription; 90-day supply: $112.50 copay/ prescription | Not Covered | Not Covered | Covered drugs in Tiers 1-4 are available up to a 90-day supply at retail pharmacies; and a 60-90-day supply via mail order. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network (You will pay the least) | PHCS Network (outside Florida) (You will pay more) | Out-of-Network (You will pay the most) | |
| | Preferred brand drugs (Tier 3) | 30-day supply: $100 copay/ prescription; 90-day supply: $250 copay/ prescription | Not Covered | Not Covered | Drugs in Tier 5 are available up to a 30-day supply, at retail pharmacies only.<br>Brand additional charges may apply.<br>Coupons or any other third-party prescription drug cost-sharing assistance will not apply toward any calendar year deductible or out-of-pocket limit. |
| | Non-Preferred brand drugs (Tier 4) | 30-day supply: 50% coinsurance; 90-day supply: 50% coinsurance | Not Covered | Not Covered | |
| | Specialty drugs (Tier 5) | 50% coinsurance (Retail only) | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Independent facility: $1,500 copay/ visit; Hospital-affiliated facility: $3,000 copay/ visit | Independent facility: $1,500 copay/ visit after deductible; Hospital-affiliated facility: $3,000 copay/ visit after deductible | Independent facility: 50% coinsurance after deductible; Hospital-affiliated facility: 50% coinsurance after deductible | Prior authorization required. |
| | Physician/surgeon fees | $50 copay/ provider | No charge after deductible | 50% coinsurance after deductible | Prior authorization required. |
| **If you need immediate medical attention** | Emergency room care | $1,000 copay/ visit | $1,000 copay/ visit | $1,000 copay/ visit | AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted. |
| | Emergency medical transportation | Ground: $150 copay/ one way ground transport; Air/Water: 50% coinsurance | Ground: $150 copay/ one way ground transport; Air/Water: 50% coinsurance | Ground: $150 copay/ one way ground transport; Air/Water: 50% coinsurance | None |
| | Urgent care | Independent urgent care facility: $125 copay/ visit; Hospital-affiliated urgent care facility: $250 copay/ visit; Retail clinic: $50 copay/ visit | Independent urgent care facility: $125 copay/ visit; Hospital-affiliated urgent care facility: $250 copay/ visit; Retail clinic: $60 copay/ visit | Independent urgent care facility: $125 copay/ visit; Hospital-affiliated urgent care facility: 50% coinsurance; Retail clinic: $50 copay/ visit after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $2,000 copay/ admission | $2,000 copay/ admission after deductible | 50% coinsurance after deductible | Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network (You will pay the least) | PHCS Network (outside Florida) (You will pay more) | Out-of-Network (You will pay the most) | |
| | Physician/surgeon fees | No Charge | No charge after deductible | 50% coinsurance after deductible | Prior authorization required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copay/ visit | 50% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization may be required. |
| | Inpatient services | $2,000 copay/ admission | 50% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization may be required. |
| **If you are pregnant** | Office visits | Routine OB or midwife: Visit 1 - 1: $40 copay/ visit; Visit 2 and after: No Charge | Routine OB or midwife: 50% coinsurance after deductible | Routine OB or midwife: 50% coinsurance after deductible | None |
| | Childbirth/delivery professional services | No Charge | 50% coinsurance after deductible | 50% coinsurance after deductible | Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). |
| | Childbirth/delivery facility services | Hospital: $2,000 copay/ admission; Birthing center: Same as routine OB | Hospital: 50% coinsurance after deductible; Birthing center: Same as routine OB | Hospital: 50% coinsurance after deductible | Prior authorization required. |
| **If you need help recovering or have other special health needs** | Home health care | $80 copay/ visit | 50% coinsurance after deductible | 50% coinsurance after deductible | Limited to 20 skilled visits per calendar year. Approved treatment plan required. |
| | Rehabilitation services | Independent facility: $80 copay/ visit; Hospital-affiliated facility: $80 copay/ visit; Chiropractic services: $40 copay/ visit | Independent facility: $100 copay/ visit; Hospital-affiliated facility: $100 copay/ visit after deductible; Chiropractic services: $50 copay/ visit | Independent facility: 50% coinsurance after deductible; Hospital-affiliated facility: 50% coinsurance after deductible; Chiropractic services: 50% coinsurance after deductible | Limited to 35 visits per calendar year for outpatient rehabilitative PT, OT, ST, cardiac rehab, pulmonary rehab, and chiropractic services combined. Cardiac and pulmonary rehab require prior authorization. |
| | Habilitation services | Independent facility: $80 copay/ visit; Hospital-affiliated facility: $80 copay/ visit | Independent facility: $100 copay/ visit; Hospital-affiliated facility: $100 copay/ visit after deductible | Independent facility: 50% coinsurance after deductible; Hospital-affiliated facility: 50% coinsurance after deductible | Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network (You will pay the least) | PHCS Network (outside Florida) (You will pay more) | Out-of-Network (You will pay the most) | |
| | Skilled nursing care | $250 copay/ admission | 50% coinsurance after deductible | 50% coinsurance after deductible | Limited to 60 days post-hospitalization care per calendar year. Prior authorization required. |
| | Durable medical equipment | $100 copay/ episode of illness | 50% coinsurance after deductible | 50% coinsurance after deductible | Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment. |
| | Hospice services | No Charge | 50% coinsurance after deductible | 50% coinsurance after deductible | Physician certification required. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | 50% coinsurance after deductible | 50% coinsurance after deductible | Limited to one exam per calendar year to determine the need for sight correction. |
| | Children's glasses | No Charge | 50% coinsurance after deductible | 50% coinsurance after deductible | Limited to one pair per calendar year from a pre-selected group of frames. |
| | Children's dental check-up | No charge for preventive care at Delta Dental Network providers | No charge for preventive care at Delta Dental Network providers | Preventive care may be subject to cost sharing if billed charges exceed allowed amount | Limited to one exam every 6 months. See the dental portion of your AvMed Contract for coverage details. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Child Dental Check Up
- Child Glasses
- Chiropractic Care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or www.floir.com/consumers, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-800-376-6651. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Florida Department of Financial Services, Division of Consumer Services, at 1-877-693-5236 or www.floir.com/consumers.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Para obtener asistencia en Español, llame al 1-800-376-6651.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$80**
- **Hospital (facility) copayment** **$2,000**
- **Other copayment** **$40**

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $2,500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,560** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$80**
- **Hospital (facility) copayment** **$2,000**
- **Other copayment** **$40**

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $2,500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,520** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$80**
- **Hospital (facility) copayment** **$2,000**
- **Other copayment** **$40**

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

The plan would be responsible for the other costs of these EXAMPLE covered services.